AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Maternity Outpatient Medical Services (MOMS) Program

Michigan Department of Community Health
Medical Services Administration

Instructions to APPLICANT:

- Please complete this form and retain the YELLOW copy for your records.
- Give the WHITE copy to the Local Health Agency.
- In order to be eligible for the MOMS Program, a Medicaid application must also be completed and submitted.
- This form is part of the Medicaid and MOMS application process.

Instructions to Local Health Agency:

- Retain the PINK copy for your records.
- Send the WHITE copy to:
  MDCH - MOMS
  PO BOX 30479
  LANSING, MI 48909-7979

Beneficiary Name	Medicaid ID Number/ MOMS ID Number		
Beneficiary Address (Number, Street, Apartment Number)	City	State	ZIP

I authorize _____

(Name of Local Health Agency)

Located at _____

(Complete Address of Local Health Agency)

To release the most current medical information (from the past 12 months), which may include medical reports, letters from physician specialists, office or hospital inpatient or outpatient summaries that review status of medical problems and ongoing treatment plans, to the Michigan Department of Community Health (MDCH) or their agents for the purposes of determining program eligibility. These records may include any information about Human Immune Deficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and AIDS Related Complex (ARC) as defined by the MDCH.

I understand that if I give permission, I have the right to change my mind and revoke it. This must be in writing to you. I understand that if this authorization is required as a condition of demonstrating criteria for eligibility in the MDCH MOMS program and I revoke the authorization, then MDCH has a right to contest my claim(s). I also understand that I cannot take back any uses or disclosures already made with my permission.

I understand that authorizing the disclosure of this health information is voluntary. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services or eligibility unless the information is necessary to demonstrate that I meet the criteria required to establish eligibility.

By signing this Authorization, I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal privacy rules. I further understand I may request a copy of this signed authorization.

Unless revoked, this authorization expires 12 months from the date signed.

Signature of Beneficiary	Date Signed	Signature of Witness (Any Adult Over The Age Of 18)	Date Signed

AUTHORITY: Public Act 368, P.A. of 1978 COMPLETION: Is Voluntary	The Department of Community Health is an equal opportunity employer, services and programs provider.

MSA-1134 (Rev. 12-03) Previous editions may be used.

COPY DISTRIBUTION: WHITE - MDCH - MOMS
YELLOW - Applicant
PINK - Local Health Agency